Authorization for Release of Medical Information

Please complete the form thoroughly by printing the answers to each of the Step Questions. Your medical records cannot be released until this form is completed and signed by you, the patient, or by the patient's parent or legal guardian.

STEP 1: Identifying information about you (the patient)

Patient's Name: ____Date of Birth: ____________

Street Address: ____

City, State and Zip Code: ____

STEP 2: Who has your medical records now?

____

Street Address: ____

City, State and Zip Code: ____

STEP 3: What medical records do you wish released?

- ☐ **All medical records** **OR**
- ☐ **Only Dates of Treatment from;** _______________________ **to:** ____________________
- ☐ **Other:** ____

STEP 4: To Whom do you wish to release your records?

☐ **Valley Eye Physicians and Surgeons** **OR** ☐ ________________________________
190 Groton Road, Suite 240 ________________________________
Ayer, MA 01432 ________________________________
Fax 978-772-3066, Phone 978-772-4000 ________________________________

STEP 5: Signature Authorization

This authorization for release of my medical records is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for re-disclosure beyond the expiration date is required.

X____ ______________________________________

Signature of Patient or Legal Guardian **Date**

STEP 6: Release of Sensitive Information

I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR ANY OTHER SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.

X____ ______________________________________

Signature of Patient or Legal Guardian **Date**

STEP 7: Release of HIV Information

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/ TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW I AGREE TO THE RELEASE OF THIS SENSITIVE INFORMATION.

X____ ______________________________________

Signature of Patient or Legal Guardian **Date**